PENISTONE

RURAL DISTRICT COUNCIL.

ANNUAL REPORT

of

The Medical Officer of Health

for the Year

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PUBLIC HEALTH COMMITTEE, 1949.

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STAFF OF THE HEALTH DEPARTMENT.

MEDICAL OFFICER OF HEALTH.

J. MAIN RUSSELL, M.B., Ch.B., B.Hy., D.P.H.

DEPUTY MEDICAL OFFICER OF HEALTH.

J. McA. TAGGART, M.B., B. Ch., B.A.O., D.P.H.

SANITARY INSPECTOR and SURVEYOR.

W. HAROLD OWEN, M.S.I.A., M.I. Mun.E.

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH

FOR 1949.

To the Chairman and members of the Penistone Rural District Council.

Ladies and Gentlemen,

I have the honour to submit my Annual Report on the Health Services for the year ended 31st December, 1949. This report has been prepared on similar lines to that for 1948. The Minister of Health requested that the report should be so prepared, and at the same time directed that special reports should be made upon certain specific matters which are mentioned below. First of all some comment was asked for upon the working of the Local Health Services under Part III of the National Health Service Act, 1946. Reports were asked for concerning water supplies, sewerage and sewage disposal. A further request has been made by the Minister for statistics concerning any outbreaks of Food Poisoning within the area, and anything that has been done in the campaign for clean food handling. All those subjects are vital to the public health of the district, and each are continually occupying the minds of the staff of the Health Department.

So far as the Part III Services of the National Health Service Act are concerned, these are services administered by the Local Health Authority, who in this instance is the West Riding County Council. You as a County District Council have no direct bearing on the administration. The Divisional scheme of Preventive Medical Services in the West Riding is so operative that the Divisional Medical Officer, who is responsible for the day to day administration of those services, is also the Medical Officer of Health to the County District Council. This is a very important fact to remember, because besides being in local contact with the district, he has an overall picture of the health services within the County as a whole, and certainly within his Division. You, being in daily contact with the people within your district, are entitled to know what services are available and what is actually being done. I am of the opinion it is a very necessary requirement on my part to supply as much information as I can, and it is precisely for this reason that in this and in previous reports I have included a summary, with comment, upon various aspects of those Local Health Authorities' Part III Services.

In that part of the report dealing with Sanitary Circumstances, Mr. Owen, the Chief Sanitary Inspector, has prepared in detail a short resume of the water supplies to each Parish, and similarly with sewerage and sewage disposal. Generally speaking, the district is fairly well supplied with a wholesome water supply, and those small hamlets which are having an intermittent supply should be satisfactorily dealt with in the near future.

In the Parish of Thurgoland, a sewage disposal scheme has been prepared and awaits Ministry approval, which will clear up a difficulty that has been an anxiety to the Health Department for many years.

To comment generally on the statistics for the Penistone Rural District for the year under review, one notices that the Birth Rate for the year was the highest for at least five years viz. 20.3 per 1,000 of the estimated population. This was considerably higher than that for

England and Wales, which was 16.7, and for the aggregate of Rural Districts within the West Riding administrative County, which was 18.4. The Death Rate increased very slightly over the low figure of last year, from 10.5 per 1,000 of the estimated population to 10.6. The equivalent rate for England and Wales was 11.7, and that for the aggregate of the Rural Districts within the administrative County of the West Riding was 10.8. In dealing with these Crude Death Rates, I must mention that this year the Registrar General has been able to supply an Areal Comparability Factor. This factor, applied to Crude Death Rates, gives an adjusted figure which makes it possible for rates in all districts to be compared one with another. After adjustment, the rate for the Penistone Rural District was 11.3.

It is a regrettable feature of the statistics for 1949 that the Infantile Mortality rate is still increasing. The year under review gave a rate of 48 per 1,000 Live Births. This is very much higher than that for the County as a whole:- 32, and for the aggregate of Rural Districts within the Administrative County of the West Riding - 42. It is a recognised fact that the Infantile Mortality Rate is one of the most delicate indices of the health of a district. Your rate has been increasing over the past 2 years. I hesitate to draw any conclusions from the figures since the numbers are rather small, but it is an indication that more care has to be given to the welfare of the newly born. The chief cause of death amongst infants in Penistone Rural District was Premature Birth and Congenital Malformation. Does this indicate the need for more Ante-Natal care !! Preventive Medicine Practitioners are fighting to get the rate down and have succeeded to a very great extent, but much still must be done. There were again no maternal deaths during 1949 - as in 1948. This is a comforting thought - the toll of deaths amongst Mothers has fallen to the low level rate of 0.98 for the County as a whole.

Before I conclude this introduction I must put on record my thanks to the Chairman and members of the Public Health Committee for their continued help and encouragement throughout the year. To the Clerk and other members of the staff I offer grateful thanks for much helpful advice. Especially do I wish to thank my Chief Sanitary Inspector, Mr. Owen, for his loyal co-operation and help.
To Dr. Taggart I offer my grateful thanks for his valuable support since his appointment in April.

I am

Your obedient Servant

J. MAIN RUSSELL,

MEDICAL OFFICER OF HEALTH.

DISTRICT STATISTICS IN BRIEF

The Penistone Rural District covers an area of 29,003 acres. The district is divided into ten Parishes. The approximate acreage and the number of houses in each Parish is as follows:-

Parish.	Acreage.	Number of Houses.
Cawthorne.	3,709	321
Dunford.	8,953	258
Gunthwaite and Ingbirchworth	2,057	113
High Hoyland.	851	48
Hunshelf	1,816	94
Langsett.	4,914	88
Oxpsring.	1,202	212
Silkstone.	1,559	466
Stainborough.	1,720.	123
Thurgoland.	2,222	477
	29,003	2,200

The Rateable Value of the district is £37,301 while the product of a penny rate is £138, 5. 9d. as at December, 1949.

VITAL STATISTICS.

POPULATION. The Registrar General has given his estimation of the population as 7,140. This is an increase of 204 compared with the 1948 figure.

BIRTHS. There were 145 live births registered in the district during 1949. Of these 82 were males and 63 females. This number is 17 more than 1948. There was one illegitimate birth, a male.

STILL BIRTHS. During the year there was one still-birth, a female. There were no illegitimate still-births.

DEATHS. During the year 76 deaths - 48 male, 28 female, were attributed to the Penistone Rural District. This is an increase of 3 on the figures for 1948. That gives a Crude Death Rate of 10.6 per 1,000 of the estimated population. The Registrar General, however, this year has been able to issue an Areal Comparability Factor. This is a factor which, when applied to the Crude Death Rate gives a final figure permitting comparison between one district andanother.

It is obvious that districts vary with regard to the age and sex distribution. It would be wrong to compare the Death Rate of a young virile population living in healthy surroundings with a Death Rate amongst a population of elderly people living under less happ y conditions. One would expect the Death Rate to be higher in the latter case. The comparability factor supplied by the Registrar General to each respective district produces a rate which can be used as a figure for comparing the relative healthiness of any two particular districts. The factor for Penistone Rural District is 1.06 which, when applied to the Crude Death Rate of 10.6

gives a finally adjusted Death Rate for the district of 11.3

Below are given some tables of Live Birth Rates, Still Birth Rates and Crude Death Rates, with similar figures for other parts of the Country. These tables are set out so that the rates for Penistone Rural District can be compared with other parts of the Country.

RATES PER 1 000 TOTAL POPULATION.

	England & Wales.	126 County Boroughs & Great Towns including London.	148 Smaller Towns (Resident Population 25,000 to 50 000 at 1931 (census)	London Administrative County	R. Penistone R.D.
			LIVE BIRTHS		
1949	16.7	18.7	18.0	18.5	20.3
1948	17.9	20.0	19.2	20.1	18.5
1947	20.5	23.3	22.2	22.7	18.1
1946	19.1	22.2	21.3	21.5	16.7
			STILL BIRTHS		
1949	0.39	0.47	0.40	0.37	0.14
1948	0.42	0.52	0.43	0.39	0.86
1947	0.50	0.62	0.54	0.49	1.03
1946	0.53	0.67	0.59	0.54	*
			DEATHS (CRUDE DEATH RATE)		
1949	11.7	12.5	11.6	12.2	10.6
1948	10.8	11.6	10.7	11.6	10.50
1947	12.0	13.0	11.9	12.8	12 07
1946	11.5	12.7	11.7	12.7	10.31

* Figures not available

PRINCIPAL CAUSES OF DEATH

INFECTIVE DISEASES.		
	Influenza	1.
CANCER of	Buccal Cavity and Oesophagus	2.
	Stomach and Duodenum	4.
	Breast	1.
	Other Sites.	10.
CIRCULATORY SYSTEM		
	Intra-cranial vascular lesions	13.
	Heart Diseases	24.
	Other circulatory diseases	4.
RESPIRATORY SYSTEM		
	Bronchitis	1.
	Pneumonia	1.
	Other respiratory diseases	1.
DIGESTIVE SYSTEM		
	Ulcer of Stomach or duodenum	1
	Diarrhoea under 2 years	1.
	Other digestive diseases	3.
GENI TO URINARY SYSTEM		
	Nephritis	1.
INFANTS		
	Prematurity	3.
	Congenital Malformations	2.
VIOLENCE	Road Traffic Accidents	-
	Other Violent Causes	1.
ILL DEFINED CAUSES.		2.
	TOTAL	76.

AGE DISTRIBUTION OF DEATHS.

Age Group	1947.	1948.	1949.
Under 1 year.	2	3	6
1 to 2 years.	-	-	1
2 to 5 years.	-	1	1
5 to 15 years.	-	2	-
15 to 25 years.	1	1	-
25 to 45 years.	4.	8	2.
45 to 65 years	17	12	14
65 years and over.	58	46	52
TOTALS:	82	73	76

INFANTILE MORTALITY.

There were 6 Infantile Deaths attributed to the district during 1949, all males, equivalent to a rate of 41 per 1,000 live births.

MATERNAL MORTALITY.

There were no Maternal Deaths during 1949.

EPIDEMIC DISEASES.

There was one death in the Epidemic Diseases (other than Tuberculosis) Group during the year, one female, aged 79 - cause of death Influenza.

INQUESTS.

In 4 cases the cause of death was certified by the Coroner after Post Mortem Examination without inquest.

NATIONAL ASSISTANCE ACT, 1948.

No action was taken under Section 47 of the National Assistance Act, 1948.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES.

Infectious Diseases other than Tuberculosis.

During the year, a total of 100 cases of Infectious Diseases were notified. The various notifications were as shown below; together with those for previous years:-

	1947	1948	1949.
Scarlet Fever	10	8	13
Diphtheria	-	-	-
Measles	71	121	51
Whooping Cough	11	45	26
Pneumonia (notifiable)	2	2	3
Acute Anterior Poliomyelitis	1	2	4
Erysipelas	4	1	1
Cerebro-Spinal Meningitis	1	-	2
TOTALS	100	179	100

ATTACK RATE OF COMMONER INFECTIOUS DISEASES.

Disease.	England & Wales			148 Smaller Towns			Penistone R.D		
	1947	1948	1949	1947	1948	1949	1947	1948	1949
Scarlet Fever	1.37	1.73	1.63	1.37	1.82	1.83	1.47	1.16	1.82
Diphtheria	0.13	1.08	0.04	0.14	0.09	0.04	0.00	0.00	0.00
Pneumonia	0.79	0.73	0.80	0.68	0.60	0.65	0.29	0.29	0.42
Cerebro-Spinal Meningitis.	0.05	0.03	0.02	0.05	0.02	0.02	0.14	0.00	0.28
Measles	9.41	9,34	8.95	9.58	8.84	9.18	10.45	17.44	7.14
Whooping Cough	2.22	3.42	2.39	2.02	3.31	2.39	2.05	6.48	3.64
Erysipelas	0.19	0.21	0.19	0.18	0.21	0.19	0.59	0.14	0.14

DISTRIBUTION OF INFECTIOUS DISEASES BY AGE GROUPS.

AGE GROUP	SCARLET FEVER			PNEUMONIA			MEASLES			WHOOPING COUGH			ACUTE POLIOMYELITIS			ERYSIPELAS			CEREBRO-SPINAL FEVER		
	1947	1948	1949	1947	1948	1949	1947	1948	1949	1947	1948	1949	1947	1948	1949	1947	1948	1949	1947	1948	1949
Under 1 years	-	-	-	-	-	-	4	1	2	3	1	2	-	-	-	-	-	-	-	-	-
1 - 2 years	-	1	1	-	-	-	5	10	3	2	4	3	-	-	-	-	-	-	-	-	2
2 - 3 years	-	1	-	-	-	-	9	18	4	1	10	4	-	-	-	-	-	-	-	-	-
3 - 4 years	1	-	-	-	-	-	5	11	4	1	8	6	-	-	-	-	-	-	-	-	-
4 - 5 years	-	1	3	-	-	-	10	17	10	2	9	3	-	-	-	-	-	-	-	-	-
5 - 10 years	7	3	9	1	1	-	36	58	25	4	11	8	-	-	1	-	-	-	-	-	-
10 - 15 years	2	-	-	-	-	-	1	3	3	-	-	-	1	1	2	-	-	-	-	-	-
15 - 25 years	-	1	-	-	-	1	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
25 - 45 years	-	1	-	1	-	2	1	1	-	1	1	-	-	1	-	1	1	1	1	-	-
45 - 65 years	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	3	-	-	-	-	-
65 years & over	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTALS	10	8	13	2	2	3	71	121	51	14		26	1	2	3	4	1	1	1	-	2

SCARLET FEVER. During the year under review 13 cases of Scarlet Fever were notified, an increase of 5 compared with the 1948 figures. The notifications were not confined to any one part of the district and the type of infection was mild.

DIPTHERIA. I am happy to report that there was not a single case of Diptheria notified during the year. There has not been a case in the Penistone Rural District for at least three years. Why is it that this disease is now under control. The decline in cases can be traced to the time when active immunisation became a routine feature in the practice of Preventive Medicine. I know there are other factors, e.g. better housing, disappearance of overcrowding, better amenities etc. but the Immunisation campaign is certainly the main cause. It is the rule rather than the exception for the mother to ask for and receive the necessary protective treatment for the child. In the Penistone Rural District during 1949 this protective treatment was provided by General Medical Practitioners and the Public Health Staff, and 55 children under the age of 5 years and 13 between the ages of 5 and 14 years received the protection. At the same time 168 children received a reinforcing dose of the antigen generally at about the age of 5 years.

I do not want a feeling of complacency to develop because there is no diptheria in the district. This immunisation business must be preached at every opportunity and every parent and guardian must be convinced that it is in the best interests of the child to receive this protection.

MEASLES. Towards the end of 1948 the Measles incidence was relatively high. The end of that year saw the peak of the mild epidemic and the end of the first quarter of 1949 shewed a decline. By the end of the second quarter the number of notifications had dropped to the minimum. Only 5 cases were notified in the second six months of the year. The incidence during 1949 was almost exclusively confined to CrowEdge and Magnum areas. I have had no reports of any resulting morbidity and the type of disease would appear to have been mild.

WHOOPING COUGH. There was a marked drop in the number of notifications of whooping cough during the year. There were 26 as compared with the 45 in 1948. Like Measles I have had no reports of any morbidity. In dealing with both Measles and Whooping Cough I would like once again to emphasise the need for greater care on the parents part when these diseases are prevalent. They are diseases caused by a virus which is harboured in the throat and nose of the affected child. One cough, or even one shout, will disseminate multitudes of these infecting organisms over a wide area. Anyone within that area will be almost sure to inhale the virus, or many of them. If susceptible and lacking the necessary resistance the person is soon a victim of the disease. With both diseases there is the predominant symptom of coughing. This in itself is an exhausting performance for any child, without the accompanying poison from the germs. They are nasty diseases and are not infrequently fatal. I wish that all parents would treat these diseases with the respect they demand. Keep the child away from all source of infection and if your child does become infected keep the child isolated until a doctor says it is safe to mix with other children.

ACUTE ANTERIOR POLIOMYELITIS. During tye year there were 4 notifications of Acute Anterior Poliomyelitis. Of these 2 cases proved to be negative after investigation. There were 2 positive cases one a girl of 10 years admitted to Lodge Moor Hospital, Sheffield and one a boy age 14 admitted to the Kendray Hospital, Barnsley. Both cases made good progress and there were no serious after effects.
The year 1949 produced another epidemic of this distressing disease. This part of the country had not the attack it had in 1948 when a relatively high incidence was experienced.

This disease is caused by a virus which attacks the nerve roots in the spinal cord and causes either an engorgement of the nerve cell contents with resultant weakness of function or it causes complete destruction of the cells with resultant paralysis.
How is it spread ? It is obvious that in an epidemic the spread is from patient to victim by droplet infection - the old story of coughing, sneezing, speaking too close to some-one- the germ passing from the infected throat to the victim. At the same time this cannot altogether account for the flare up of the disease at certain times of the year. The germ has been isolated from the sewage from an urbanised area where the disease was prevalent. We know it is passed in the bowel contents of the infected person. Is it too much to believe that the disease is kept alive by faulty personal hygiene ? During high summer the disease appears and in all probability the germ came from the bowel of an active carrier.
I am often asked what precautions can be taken to avoid becoming infected. This is not too easy to answer-- in fact I doubt if there is a complete answer in the light of the incomplete knowledge of the mode of transmission of the disease. But there are one or two things which we all can do and which will help a great deal. Live a normal life getting as much fresh air as possible and particularly so in the sleeping quarters. Avoid crowded places when the atmosphere is not too wholesome. Protect the nose and mouth when coughing and sneezing and do all you can to get others to do the same. Be certain that after each visit to the toilet the hands are washed THOROUGHLY and most certainly before a meal. During the time when the disease is epidemic see that the children do not get overtired. There is a lot to be said for the habit of "early to bed", even in high summer. Above all it is essential that people do not get over-anxious about this disease.

TUBERCULOSIS. During the year 5 new cases were notified -- 4 Pulmonary and 1 Non-Pulmonary. Each case was followed up by the Tuberculosis Health Visitor and contacts were called for examination.
In that part of the report dealing with General Public Health I have commented more fully upon Tuberculosis and the part the District Council can play in the fight against it.
No action was taken under the Public Health (Prevention of Tuberculosis) Regulations, 1925 or under Section 172 of the Public Health Act. 1936.

INFESTATIONS. No case of infestations was reported to me during the year under review. As mentioned in the report dealing with school medical inspections there were some mild infestations amongst the children. As the figures are for the division one cannot say how many, if any, of these refer to Penistone Rural District. Whilst these figures would suggest that the children concerned did not have the care and attention they should have with regard to the cleanliness of the hair one cannot report that there was any real infestation in the district. Scabies seems to have been absent. At least its presence was never enough to warrent a report to the Health Department.

GENERAL PROVISION OF HEALTH SERVICES.

HOSPITALS. All Hospital facilities are now the responsibility of the Sheffield Regional Hospital Board. Cases of Infectious Diseases are usually admitted to the Kendray Isolation Hospital, Barnsley, although some are sent to the Lodge Moor Hospital, Sheffield.

Maternity cases requiring admission to Hospital are admitted to the Princess Royal Maternity Home, Huddersfield, the St. Helen Hospital, Barnsley and the Hallamshire Maternity Home, Chapeltown. I am still consulted with regard to the degree of priority for applications for admission, but there my liaison ends. I think that Medical Officers of Health might have a bigger say in the question of Hospitalisation of Maternity cases. As stated in another part of this report there are certain priorities for the admission of cases to Maternity Hospitals. But there are other cases where there might be a psychological background which is well known to the Medical Officer of Health and his Health Visitors, but which is difficult to put on a questionaire in the form of a statement. There are those fundamental little elements connected with the environmental background of an expectant Mother, known only to the Medical Officer of Health and the Health Visitor, which sometimes are of greater importance than being one of the category of priorities mentioned. Happily, in this area I am exceedingly fortunate in that I do get sympathetic consideration from the Medical Superintendents in the Maternity Hospitals /Homes in the immediate neighbourhood.

LABORATORY FACILITIES. All the necessary facilities for bacteriological laboratory work are available at the Wakefield Laboratory of the Medical Research Laboratory.

AMBULANCE FACILITIES. The West Riding County Ambulance Service provides the services generally. An Ambulance is stationed at a Sub-Depot in Penistone, which will answer any emergency calls. It is, however, part of the Depot which is stationed in Hoyland, and which covers the entire district.

CLINICS. An Infant Welfare Centre is established at Cawthorne and use is also made of the one at Penistone.

There are no Ante-Natal Clinics in the area. Ante-Natal services are provided by the General Medical Practitioners under their terms of agreement with Executive Councils.

MORTUARY. The public Mortuary at Penistone serves the Parishes adjacent to the Centre, whilst other Parishes use the Mortuary at Dodworth.

FOOD POISONING.

This is a subject which commanded a great deal of attention during 1949. It has always been a matter of vital importance that the food we eat should not only be wholesome in quality, but should not in any way be contaminated, and thus liable to cause Food Poisoning. I was privileged during theyear to attend a lecture in the London School of Hygiene on the subject of Food Poisoning, and was amazed at the extent of the problem. Food Poisoning may be caused by the appearance in the food of metals obtained from the utensils in which the food was cooked, or any other accidental ways. Outbreaks of metallic Food Poisoning are very rare. The main causes of Food Poisoning today are bacterial. Organisms of the ordinary Blood Poisoning group, the Dysentery group, the Typhoid group, are the principal offenders. No one can suffer from Food Poisoning who has not swallowed the germ. Germs are transmitted from the infected person by:

(1) Moisture from the nose and throat, e.g. in cases of Septic Tonsillitis.

(2) From Septic Foci on hands and arms, face, etc.

(3) Through the bowel contents and occasionally the urine contents, e.g. Dysentery Typhoid and its allied organisms.

Food Poisoning, therefore, is a type of infection which is eminently preventable. If everyone adopted strict attention to personal hygiene, I doubt if we would ever have a case of organismal Food Poisoning. Scrupulous care in the covering up of the nose and throat to avoid droplet infection, to the complete occlusion of all Septic Foci on the body, and the insistance upon thoroughly washing hands after using the Toilet, are common sense routine principles to adopt.

During the year there were no cases of Food Poisoning notified in the Penistone Rural District.

I must emphasise that the symptoms of Food Poisoning are demonstrated as an attack of Acute Gastro Enteritis, Diarrhoea, and sometimes Sickness. It has been said that all cases of sickness and diarrhoea are really Food Poisoning. I have heard from time to time that there had been "a lot of diarrhoea in one part of the district". I never got to know about the outbreak, and although each rumour was investigated, no positive evidence upon which we could work was forthcoming. If a case of Food Poisoning has got to be investigated epidemiologically, with a view to eliminating the cause, it is essential that the Medical Officer of Health must know about the case at once. Twenty-four hours delay is sometimes too late. I do not consider it is necessary to leave it to the General Practitioner to notify the Medical Officer of Health. The head of the house in which the infection occurs should be encouraged to report to the Health Department when any symptoms like those of Food Poisoning are prevalent within the home.

We must concentrate on instructing the public in the hygiene of food handling. During the latter part of the year I discussed the matter at certain Parent Teacher Association Meetings at School, and I mentioned it occasionally in School Canteens during the course of routine visits. During the first few days of 1950 it was arranged that I should give a comprehensive lecture on this subject to a gathering of food handlers in Schools in the hall of the Ecclesfield Grammar School.

We must face up to this problem of Food Poisoning, for there is no doubt that there has been an increase in the amount of Food Poisoning since the commencement of the last War. In 1940, 150 outbreaks were reported, and in 1949, 800 outbreaks

were reported throughout the Country. Some of those cases were sporadic outbreaks in one's and two's. The feeding habits of the people changed during the last decade. There was hardly a home where someone did not eat out in Communal Feeding Centres, School Feeding Centres, cheap eating houses etc., etc. The chances of infection were thus very much more enhanced. Of course, there is also the predisposing factor of an increased consumption in the amount of prepared food, such as Pies, Sausages, Brawn, etc. They are made in Factories, transported to retailers, then to Shops, where they may be kept for days on end. There is far too much handling, and far too little provision for keeping the goods at a temperature where bacterial growth will not take place. Then there is the question of the ordinary house fly, whose relationship to the spread of infection is proverbial. It seems to me, therefore, that most of the Food Poisoning in the Country would be eliminated if food were handled with more care.

HEALTH EDUCATION.

Besides Health Education in matters of clean food handling, I am convinced that the more the public at large are informed about health matters generally, the more interested they become in the manner in which they live. Health Education is a most important factor in the Public Health Department's work, and every opportunity is taken to talk to groups of people on health matters.

The West Riding County Council provide posters prepared by the Central Council for Health Education, and these are available for show throughout the area. It is my intention to take advantage of every poster and every pamphlet that is available. At the present moment posters are issued to Clinics, and in most of those buildings small pamphlets are issued on various aspects of public health.

Upon reflection, I am more convinced than ever that the people generally will co-operate and will act upon any advice given by the Health Department if they have already had explained to them the advantages of the principles concerned. It is my intention to take every opportunity to inform the public on matters which vitally affect their health.

SANITARY CIRCUMSTANCES.

(Prepared by W.Harold Owen)

There are 2207 houses in the District, of these 1872 have public water supplies from the following undertakings.
Cannon Hall Estate,
Barnsley Corporation
Denby Dale Urban District Council
Holmfirth Urban District Council
Sheffield Corporation.
Penistone Urban District Council.
Penistone Rural District Council.

Houses on Mains Supply.

All the houses on the mains supply have water laid to the Sinks.

Sources of Water Supplies.

The supplies from the Barnsley Corporation Sheffield Corporation and Denby Dale Urban District Council, are from Upland Surfaces, impounded filtered and chlorinated and are soft waters.
The Supply from the Cannon Hall Estate is from a deep bore hole, Well, and underground catchment being hard water.
The supply from the Penistone Urban District Council is from four deep Boreholes, being hard water, and from Upland Surfaces being filtered and chlorinated. The Supply from the Holmfirth U.D.C. is from surface springs and upland surfaces, being soft water.

Distribution.

Parish of Cawthorne.	Distribution in part, privately, by the Cannon Hall Estate, remaining distribution by the Rural District Council, water obtained in bulk from the Barnsley Corporation. Cannon Hall Estate, Darton Urban District Council, a take from their bulk supply from Penistone Urban District Council.
Parish of Dunford	The District Council distributes the Public supply at Dunford from a source vested in them, and likewise at Townhead. The District Council distributes a public supply purchased in bulk from the Penistone Urban District Council at Hazlehead, Crowedge and other small isolated hamlets in the Parish.
Parish of Gunthwaite & Ingbirchworth.	The District Council distribute the Public supply purchased in bulk from Barnsley Corporation, to the built up area at Ingbirchworth. This Parish is in Barnsley Corporation's Statutory area of supply.
Parish of Hunshelf	Supplies distributed to part of the built up area of the Parish from the District Councils own source at Blackmoor Common. Hunshelf is in the Barnsley Corporation's Statutory area of supply.

Parish of High Hoyland	Supplies distributed by the Rural District Council and purchased in bulk from the Denby Dale Urban District Council.
Parish of Langsett.	Supplies distributed in the built up area by the Sheffield Corporation.
Parish of Oxspring.	Supplies distributed by the Rural District Council and purchased in bulk from the Penistone Urban District Council.
Parish of Stainborough	Supplies distributed by the District Council, purchased in bulk from the Barnsley Corporation. This Parish is in the Barnsley Corporation's Statutory area of supply
Parish of Silkstone.	Supplies distributed by the Barnsley Corporation, being their Statutory area of supply.
Parish of Thurgoland.	Supplies distributed by the District Council to the built up area of the Parish from own sources. The remaining isolated cottages and farms obtain their water from wells and springs.
Extension of Supplies.	No extensions have taken place during the year, other than mains to Housing sites.
Proposed Extensions.	A scheme has been prepared to provide a public supply to the unsupplied area of Greenmoor, and isolated Farms and cottages in the Parish of Hunshelf. A scheme is being prepared to provide a Public supply at Roughbirchworth. A scheme is to be prepared for a public supply to several Farms and Cottages at Copster A scheme is being prepared for a Public supply at Carlecotes, and an improvement to the supply at Crowedge A scheme is to be prepared for a Public supply to the Hamlet at Lower Greaves, Cawthorne
Samples.	During the year, 5 samples of water were submitted for a report. 1 on the Mains supply at Baggerwood, Stainborough 2 on the Spring Supply at Blackmoor Common 1 from Private Supply to Sycamore Cottages, Oxspring. 1 from an existing Bore Hole, West of Carlecotes Village. 4 were found satisfactory, and one doubtful, the Bore Supply
Complaints as to Shortage.	Intermittant supplies to Crowedge Village and to Berry Moor, Thurgoland.
Complaints as to Quality.	Apart from complaints received from the source at the Pashley Green supply at Cawthorne, the Districts appear to have been well served. Proposals are under consideration to improve the supply in question.

Sewerage and Sewage Disposal.

Sewerage.

Of the 2207 Houses in the District 1466 are connected to public or private sewers.

The sewage from the remaining 741 houses being disposed of by private arrangement, such as Cess Pits, Septic Tanks, with Filters and land irrigation. The largest group of houses not connected to sewers being at Dunford Bridge, (15) Carlecotes, (23) Crowedge (43) Ingbirchworth (15), High Hoyland (21), Oxspring (15), Thurgoland (20), and Greenmoor (18) Schemes have been prepared for the provision of sewers at Ingbirchworth High Hoyland, and Cranemoor A sewer has been provided at Dunford Bridge for the reception of the drainage from the Houses in the built up area.

Sewage Disposal.

Parish of Cawthorne

The sewage from the built-up area of Cawthorne is dealt with at Dark Lane Sewage Disposal Works, where a modern system of plant exists, and at Clay Hall. A scheme is to be prepared for transferring the major volume of sewage from Clay Hall to the Dark Lane Works.

Parish of Dunford.

No works exist for the sewage to the built up area of Carlecotes, and Crowedge. A modern works is almost complete for the Village of Dunford Bridge.

Parish of Gunthwaite & Ingbirchworth.

No plant exists for the sewage of the built up area of Ingbirchworth. A Scheme has been prepared and awaits the Ministry's sanction to proceed.

Parish of Hunshelf.

No plant exists for the sewage to the built up area of Greenmoor. A Scheme has been prepared to deal with the matter when the time is opportune.

Parish of High Hoyland.

No works exist for the sewage to the built up area of the Parish A scheme has been prepared and awaits the Ministry's sanction to proceed.

Parish of Langsett.

The sewage to the built up area of Langsett is dealt with by plant vested in the Sheffield Corporation.

Parish of Oxspring.

The sewage to the built up area of the Parish is dealt with by plant situated adjacent to the Bower Hill River Bridge Deemed to be overloaded in the absence of a second Filter bed.

Parish of Stainborough.

The sewage to the built up area is dealt with by plant situated on the North Side thereof deemed obsolete The Hamlet at Ratten Row is dealt with by plant comprising settling tank and irrigation area.

Parish of Silkstone.

The sewage to the built up area of Silkstone is dealt with at existing plant situated on the East Side of the Old Wagon Road, Silkstone. The

Parish of Silkstone cont.	built up area of Silkstone is dealt with at existing plant near Throstle Nest Farm, (Silkstone Common).
Parish of Thurgoland.	The sewage from the built up area of Thurgoland is dealt with at works adjacent to Sharpe Forge Bridge. The sewage from the Nook at Cranemoor and Cranemoor built up area is dealt with at works near Cliffe Bridge, deemed to be obsolete. A scheme for new works has been prepared and awaits Ministry's sanction to proceed.

Conversion of Privies and Pan Closets.

16 Privies and Pan Closets were reconstructed as Water Closets.

Parish.	Situation.	Remarks
Thurgoland.	Cranemoor Nook	2. Privies.
	Mount Pleasant Cranemoor.	4. do
	Fir Tree, Thurgo	2. do
	Shops, Thurgoland	2. Pans
Cawthorne	Norcroft Farm	1. Privy.
Thurgoland	New Bailey Cranemoor	4. Privies
Oxspring.	Clays Hall Farm	1. Privy

Additional Closets

12 Closets were provided for old property as water closets.

Parish	Situation.	Remarks.
Thurgoland.	Shanton, Thurgoland.	1.
Dunford.	Middlecliffe Farm.	1.
Cawthorne.	Small Holding Darton Road. (Walker)	1.
Thurgoland.	Mount Pleasant Cranemoor.	2.
Oxspring.	Four Lane Ends (Shop)	1.
Thurgoland.	Bearn Cottage	1.
do	Cranemoor.	
do	New Bailey, Cranemoor	5.

Constructed as Water Closets for New Houses.

199 Water Closets were constructed for new Houses.

Parish.	Situation.	Remarks.
Gunthwaite & I.	Wellthorne Avenue	16.
Dunford.	Whitley Terrace.	12.
Silkstone	Viewlands.	44.
Oxspring.	Mayfield	36.
Cawthorne.	Stanhope Avenue	36.
High Hoyland.	Upperfield Lane.	20.
Silkstone.	Manor Park.	10.
Dunford.	Crowedge.	2.
Stainborough.	Hood Green.	2.
Silkstone.	Ben Bank Road.	1.
do.	Cone Lane.	1.
Stainborough	Stainborough Castle	1.
do.	do	10.
Gunthwaite & I.	Wellthorne Lane.	1.
Stainborough.	Hostels	7

The table as follows summarises the position as to Water Closets, Pan Closets, Privies, Ash Fits, Sanitary Bins, and Middens 1949.

Parish.	Houses.	Water Closets.	Privies.	Pan Closets.	San/Bins.	Open Mid.
Cawthorne.	321	312.	69	12	194	
Dunford.	258	105.	61	40	84	
Gunthwaite.	113	59	73	3	56	
Hunshelf.	94	15	86	3	10	
High Hoyland.	48	34	24	1	18	
Langsett.	88	10	45	36	15	
Oxspring.	212	206	36	3	187	
Stain-borough.	130	107	69	1	80	
Silkstone.	466	433	47	6	355	
Thurgoland	477	255	239	3	223	
	2207	1536.	749.	108.	1222.	50.

Refuse Collection and Disposal.

The whole of the Rural District is Publicly Scavenged. Two Refuse Collection Vehicles are employed fully for this service, both being vested in the ownership of the District Council.

Details of Vehicles.

Make.	Capacity.	Date of Manufacture.
Karrier Bantam.	2 tons, 7 C. yards	1947
Karrier C.J.C. Type.	3-4 tons, 10 C. yards.	1948.

Staff Employed. Two Drivers 4 Loaders.

Disposal of Refuse.

Refuse entirely disposed by Tipping (uncontrolled) at the following sites.

Parish.	Situation.
Cawthorne.	Low Mill Farm, Darton Road, Cawthorne.
Dunford.	Quarry, Carlecotes.
Gunthwaite & Ingbirchworth	Quarry, Carr Lane, Gunthwaite.
Hunshelf.	Quarry, adjacent to Well Hill, Greenmoor.
High Hoyland.	As Cawthorne.
Oxspring.	As Hunshelf.
Stainborough.	Strafford Colliery, Gilroyd.
Silkstone.	Cone Lane.
Thurgoland.	Copster Quarry, and as Hunshelf.
Langsett.	As Dunford.

Costs of Collection. £2,400.

Salvage of Waste.

Owing to the difficulty of the sales for paper, the collection of this waste, was suspended. Other wastes such as Scrap Iron, and Rags realised very little.

Sanitary Inspections. Nuisances.

During the year, 100, visits were made for the detection and abatement of Nuisances.

Nuisances found in 1949 - 42.
do in hand 1948 - 28.
Total needing Abatement - 70
Abated during 1949 - 39
Outstanding end of 1949 - 31.

Classification of Nuisances Found.

Obstruction to Drains.	9.
Defective Range Fixtures.	3.
Undrained buildings.	1.
Defective Eaves Gutters and Fall pipes	6.
Defective Sanitary Fixtures.	2.
Defective Private Sewer.	1.
Defective Drains.	3.
Defective Closets.	1.
Defective Chimney Stack.	1.
do Roofs.	1.
Dry Rot to Floor Boards.	1.
General Housing Defects.	5.
Overflowing Septic Tank.	1.
Defective Privy Midden	1.
Defective Plaster.	1.
do Roofs	2.
Undrained building.	1.
Untrapped Sink Waster.	1.
Defective Sink Waste.	1.
	42.

Housing.

During the year, Council Houses have been erected and occupied in the following Parishes.

Cawthorne.	18.	Stanhope Avenue.	Airey Rural.
Dunford.	6.	Whitley Terrace.	do.
Silkstone.	22.	Viewlands, Silkstone Common.	do.
do	5	Manor Park.	do
Gunthwaite & Ingbirchworth	8		
High Hoyland	10	Wellthorpe Avenue	Traditional.
Oxspring.	18	Upperfield Lane.	Airey Rural.
		Mayfield.	do.
	87		

New Dwellings by Private Enterprise.

Parish.	Name.	Type.	Situation	No.
Dunford.	Hepworth Iron Co.L.	Detached.	Crowedge.	1.
Stainborough	National Coal B.	do	Hood Green.	1.
Silkstone.	J.Walton.	do	Cone Lane.	1.
do	S. Sykes.	do	Ben Bank Road	1.
				4.

Verminous Houses.

During the year no Infestations have been notified as requiring attention.

Inspection and Supervision of Food.

Milk.

Since the Minister of Agriculture and Fisheries accepts responsibility under the Milk and Dairies Regulations 1949 for the registration of all persons carrying out the trade of Dairy Farm and of all Farms and the conduct of production inspections are undertaken by the said department.

Milk (continued).

The Supplementary Licences have been issued for the sale and distribution of bottled tuberculin tested and pasteurised milk, to the Barnsley British Co-operative Society.

Ice Cream.

One establishment is registered for the manufacture of ice cream by retail on own premises. 6 visits were made to the premises, conditions being satisfactory.
G. Fieldsend, The Stores, Cawthorne.

Meat and other foods.

The registered (1) and licensed (8) Slaughter houses in the District are now occasionally used for the Slaughter of Pigs for feeders own consumption. No cases have come to notice of food unfit for consumption.

Rats and Mice Destruction Act, 1919 - Infestation Order 1943.

The Rat nuisance has been more prevalent this year, particularly by complaints from Householders, and probaits and poison baits have been laid to arrest the pests. Similar action has been taken as Sewage Disposal Works, and it is estimated that the kills have been favourable.

Moveable Dwellings.

The number of resident movable dwellings in the District remain at 12. There appears to be an increase of such dwellings used for weekend and summer uses only.

Shops Act 1912 - 1938.

34 Shops remain on the register, inspections have been made to most of these, and the sanitary requirements where seen, satisfactory.

Building Bye - Laws - Application for permission to Develop Land.

The undermentioned applications were received, and plans deposited and approved.

Proposal.	Applicant.	Site.
Fish and Chip Shop.	Mrs. Brown.	Old Mill Lane Thurgoland
Garage.	Mr.O.H.Smith	Opposite Brick Row, Crowedge
Extension to Concrete Wks.	Messrs. Beever Concrete Co.	Wellthorne Lane, Ingbirchworth.
Barrel Slide & Porch.	Messrs. Richdale & Co.Ltd.	Travellers Inn, Foxhouse.
Garage.	Mr.John Alderton	Pot House, Silkstone.
Garage.	Mrs. Crossland.	Victoria House, Cranemoor.
Cowshed.	Mr.E. Wood.	Opposite Thorncliffe Terr., Silkstone Common.
Detached House.	Railway Ex.	Dunford Bridge.
Conversion of Building for Office.	Capt. Wentworth	Wentworth Castle, Stainbro.
10 Houses.	Railway Ex.	Dunford Bridge.
Substation.	Yorkshire E.B.	Mayfield Estate, Oxspring.
Prefabricated Huts.	Barnsley Corporation. Education C.	Wentworth Castle, Stainbro.
Pair Houses.	National Coal Board	Hood Green, Stainbro.
Bridge Alterations.	Railway Ex.	Cote Bank & Ranah Bridges.

Proposal.	Applicant.	Site.
House.	F. Robinson.	Viewlands, Silkstone Common.
Bungalow.	James & D. Gough.	do. do.
do	Selwyn Auckland.	Opposite School House. High Hoyland.
Pair Houses.	Tivydale Colliery Co.	Adjacent to Colliery.
		Canteen Silkstone Lane.
Closet Accommod-ation.	C. Bates.	Railway House, Hazlehead.
Playing Fields	Messrs. David Brown & Co.Ltd.	Oxspring.
Garage Extension.	Mr.E. Thorpe	Tontine, Thurgoland.
Piggery.	Mr.E. Wood.	Opposite Thorncliffe Terrace, Silkstone Common.
Greenhouse.	Mr.J. Sykes.	East of Orchard Terrace. Cawthorne.
Workshop	Mr.J. Laver.	Old Mill Lane, Thurgoland.
Fan House.	General Refractor-ies.	Bullhouse Mine, Fulshaw.
Sign.	Messrs. John Rich-dale L.	Travellers Inn, Foxhouse
House.	W. Kent.	Kirkfield, Cawthorne.
2 Cottages.	G. Roberts.	Near Flouch.
Coal Abstraction	General Refractories L.	South of Hartcliffe Road at Fulshaw.
Garage.	F.N.Kaye.	at Carlecotes.
Garages (2)	National Coal Board.	New Houses, Hood Green, Stainborough.
Garage.	Mr.A. Goldthorpe.	Kirkwood Mill, Oxspring.
Prefabricated House	Mr.J. Goldthorpe.	do.
Garage.	Mr.D. Whitfield.	Crossways, Stainborough.
Garage.	Mr.Vincent Hodgson.	Co-operative Stores, Cawthorne.
Outbuildings	Mr.F. Webster.	Hill Side, Hazlehead.
House.	Mr.J.B.Brooke.	Kirkfield, Cawthorne.
Garage.	Mr.J. Richards.	Round Green, Stainborough.
Alterations.	Mr.S.Hinchliffe.	Lostowder, Darton Road, Cawthorne.
Larder and Coals.		
New Conveniences.	Messrs. Barnsley Brewery Co.Ltd.	Eastfield Inn, Thurgoland.
Sign.	Mr.G.L. Stirling.	Green Lathes Farm, Cawthorne.
Garage.	Hepworth Iron Co.	Colliery Managers House, Crowedge.

GENERAL PUBLIC HEALTH.

Summary of Vital Statistics - 1949.

Area of Division.	89,923 acres.	
Estimated Population (Mid. Year 1949).	82,500	
	1948.	1949.
Birth Rate (per 1,000 estimated population).	18.4	17.2
Death Rates (all per 1,000 estimated population).		
All Causes.	8.8	9.6
Cancer.	1.22	1.41
Heart and Circulatory Diseases.	3.11	4.63
Zymotic Diseases.	0.14	0.03
Respiratory Diseases.	0.88	1.16
Respiratory Tuberculosis.	0.25	0.30
Other forms of Tuberculosis.	0.04	0.07
Infantile Mortality.	26	24
Diarrhoea - Deaths in infants under 2 years of age.	4.16	2.82
Maternal Mortality.	Nil.	Nil.

B I R T H S.

The number of Live Births registered within the Division during the year was 1,418 (males 750, females 668). This was equal to a rate of 17.2 per 1,000 of the estimated population.

During the year 33 still births were registered. Illegitimate Births totalled 31 - 17 males and 14 females.

D E A T H S.

The deaths in 1949 numbered 796 (males 453, females 343), the death rate from all causes being 9.6. The following table shows the mortality in the Division from the various causes.

CAUSES OF DEATH.

Cerebro-Spinal Fever	1
Tuberculosis of Respiratory System	25
Other forms of Tuberculosis	6
Syphilitic Diseases	3
Influenza	11
Acute Poliomyelitis and Polioencephalitis	2
Cancer of buccal cavity and oesophagus (males)	5
Cancer of the uterus (females)	4
Cancer of the stomach and duodenum	29
Cancer of the breast	10
Cancer of all other sites	75
Total - all forms of Cancer	123
Diabetes	3
Intracranial vascular lesions	97
Heart Diseases	237
Other Diseases of the Circulatory System	50
Bronchitis	46
Pneumonia	28
Other respiratory diseases	9
Ulcer of stomach or duodenum	7
Diarrhoea under 2 years	3
Appendicitis	1
Other digestive diseases	10
Nephritis	17
Premature birth	12
Congenital malformation, birth injury, infant diseases	23
Suicide	2
Road Traffic Accidents	5
Other violent causes	21
All other causes	54
TOTAL - all causes	796

ANNUAL RATES PER 1,000 OF THE ESTIMATED POPULATION

	Live Birth Rate.		Death Rate.		Zymotic Death Rate.		Respiratory Diseases Death Rate.		Heart and Circulatory Diseases.		Cancer.		Tuberculosis Death Rate.		Infant Mortality.		Diarrhoea (Deaths under 2 per 1,000 Live Births.)	
	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949
Division 22.	18.4	17.2	8.8	9.6	0.14	0.04	0.88	1.01	3.11	3.48	1.22	1.49	0.29	0.38	2[illegible]	33	4.16	2.10
U.D's. in West Riding.	18.3	16.8	11.8	12.5	0.12	0.08	1.34	1.48	3.98	4.36	1.83	1.88	0.44	0.37	38	37	4.17	3.01
R.D's in West Riding.	19.2	18.4	9.8	10.8	0.12	0.09	0.15	1.31	3.03	[illegible]	1.49	1.61	0.43	0.37	40	42	4.97	3.95
West Riding Administrative County.	18.5	17.2	11.3	12.1	0.12	0.08	1.29	1.44	3.73	4.19	1.74	1.81	0.4[illegible]	0.37	39	38	4.38	3.27
England and Wales.	17.9	16.7	10.8	11.7	x	x	x	x	x	x	1.86	1.87	0.51	0.45	34	32	3.3	3.0

x Not available.

CARE OF MOTHERS AND YOUNG CHILDREN.

Estimated population 1949.....	82,500
Number of Live Births.....	1,418
Number of Illegitimate Births.....	31
Number of Still Births.....	33
Estimated child population (0 - 4)..... (Supplied by Registrar General).	8,453
Estimated child population (5 - 14)..... (Supplied by Registrar General).	12,015

In Division 22 the care of Mothers and young children is one of the most important sections of the Divisional work. In the tables below I set out statistics concerning the Child Welfare Clinics and Ante-Natal Clinics. In the Division there are 14 Child Welfare Clinics and 6 Ante-Natal Clinics. It is possible that in certain areas Ante-Natal Clinic facilities might not be available, and in those instances arrangements are made for the expectant Mother to receive her Ante-Natal care at the Child Welfare Centre. Such places as Grenoside, Loxley, Oughtibridge, Stannington, Worrall and Cawthorne are covered in this way. There are 11 Infant Welfare sessions held each week, and at 3 Centres a Clinic is held once a fortnight. There are 4 weekly sessions of Ante-Natal Clinics and in 4 cases a session is held once a fortnight. During the year over 15,000 attendances at the Clinic were recorded of children under the age of one year, and practically 10,000 attendances of children over one year. This shows an increase over the 1948 figures. Some of this increase might be attributed to the tremendous increase in the work at Ecclesfield Clinic, where the influx of residents on the new Parson Cross Estate means a large increase in Clinic attendances.

It is the policy of the County Council, so far as is possible, to employ full-time Assistant County Medical Officers to conduct the Child Welfare Clinics. There are two full-time Assistant County Medical Officers employed in Division 22, and it is obviously impossible for those two Officers to cover the whole of the Division. Therefore, General Practitioners are employed on a sessional basis. Six sessions a week and one session a fortnight are conducted by General Practitioners.

I think that it is safe to say that in no other section of the Public Health Service is there a more practical example of Preventive and Social Medicine than one finds in the Welfare Clinics. Here we have the Mother and the baby attending regularly at a weekly session. What do the Mother and baby receive for their trouble in attending the Clinic? I am sure the explanation is that the Clinic has become recognised as a place not where a Medical Service is available, which implies treatment, but rather that a Health Service is available where the conception of health is given a wider significance than one would expect in a Health Centre which was a Centre of group Medical practice. At a Clinic the young Mother meets other young Mothers, meets the Medical Officer to discuss confidential medical details, meets the Health Visitor who is her adviser on medico-social matters, and in some cases she meets the Midwife who will be attending her in her confinement, either in the capacity of a Midwife, or as a Maternity Nurse. From time to time demonstrations are available on such matters as dieting, clothing, care of the teeth, sleep, rest, etc.

I mentioned in my report for 1948 that it was amazing how much good work is done in those Clinics despite the relatively poor condition of the premises in some instances. There are those who argue that the premises are not of great importance, but that the service is what counts.

There are others who say that whilst they agree that the service is important, the premises in which the Clinic is conducted are also important. In some cases Mothers visit a Clinic for advice on health matters, and the premises in which the Clinic is conducted are far away inferior to those of her own home. I know that there are difficulties, and they are not only financial, in the establishment of proper Clinic premises. It is envisaged in the new National Health Service Act that Health Centres will be built by the Local Authority, and in those premises there will be proper Clinic facilities. In the waiting period it would appear that we must make the best use of what we have at the moment. My own opinion is that I doubt whether it is a wise procedure to put a Child Welfare Clinic in a Health Centre, which is a Centre of group Medical practice. We begin to think of a Medical Service then, and not a Health Service.

ANTE-NATAL CLINICS.

Ante-Natal Clinics are conducted in one instance by one of the full-time staff, and in the others by General Practitioners who have a particular leaning towards Obstetrics and Gynaecology. Ante-Natal services in Division 22 are feeling the strain of the new Health Service Act, and the attendances at some Clinics have dropped to nothing. In one instance closure is recommended.

The remuneration paid to General Practitioners for the undertaking of Midwifery Service is such that a certain fee is included for Ante-Natal Services. Now, General Practitioners who are keen on this aspect of the work naturally prefer to supervise their Ante-Natal cases in their own Consulting Rooms, and in their own established Clinics. I think it is a natural thing for them to do. This is happening to such an extent in Division 22 that the expectant Mothers are not attending the Local Authority's Ante-Natal Clinic. I suppose that the fundamental is attained in that the expectant Mother is being well cared for and there the matter ends. But does it ? I am still old fashioned enough to believe that the arrival of a baby in a home is pre-eminently a natural family event, and it is a tremendously important social event in the family. I would like to think that the Mother to be is equipped mentally and physically to deal with this important event.

I am sorry that the Mothers are not attending the established Ante-Natal Clinics, for there is very much more to the Ante-Natal care of an expectant Mother than purely medical care. At the Clinic they meet other expectant Mothers and they talk with them. At the Clinic they meet the Health Visitor, who can teach them certain important matters in connection with the medico-social aspect of the coming event; and at the Clinic they meet the Midwife who will attend them when they are confined, at least as the Maternity Nurse. No, I am afraid I am one of those who prefers to have the Ante-Natal Clinic as a Centre where expectant Mothers can come and talk with others similarly placed, and with the Doctor and the Midwife and the Health Visitor who can mean so much to them. In one part of Division 22, in Ecclesfield, the Ante-Natal Clinic is a tremendous Centre for such work, and it is so popular that in all probability an extra Clinic will have to be arranged.

CHILD WELFARE CENTRES.

Name and Address of Centre. Name of Doctor and Nurse in attendance.	Day and Time of sessions.	Total number of attendances during the year.	
		Number who attended for first time during this year.	Children up to 5 years.
CHAPELTOWN. Miners' Welfare Pavilion. Dr. A. Anderson & Miss E. Gerrard.	Wednesday afternoon.	93	2403
ECCLESFIELD. Gatty Memorial Hall. Dr. A. Anderson & Miss B.S. Ward.	Monday afternoon.	295	3903
GRENOSIDE. Scout Hut. Dr. B. Droller & Miss B.S. Ward.	Tuesday afternoon.	80	1377
HIGH GREEN. Methodist Sunday School, Wortley Rd. Dr. J.M. Taggart & Miss.E. Gerrard.	Tuesday afternoon.	90	1837
LOXLEY. Congregational Chapel. Dr. S. Lindsay & Miss.G.A. Gosney.	Alternate Tuesday afternoons.	64	410
CUGHTIBRIDGE. Church Hall. Dr. S. Lindsay & Miss.D.Sill.	Thursday afternoon.	45	1688
STANNINGTON. Methodist Sunda y Schaol. Dr. S. Lindsay & Miss G.A.Gosney.	Wednesda y afternoon.	51	1582.
WORRALL. Memorial Hall. Dr. S. Lindsay & Miss G.A. Gosney.	Alternate Tuesday a fternoons.	19.	811
TANKERSLEY. Scout Hall. Dr. E. Allott & Miss D. Rimmer.	Alternate Monday afternoons.	16.	329
HOYLAND. Miners' Welfa re Institute. Dr. J. Allott & Miss M.F. Senior.	Tuesday afternoon.	151.	3236
HOYLAND COMMON. Christ Church, Hoyland Road. Dr. M. Allott & Miss D. Rimmer.	Thursday afternoon.	100	3128
PENISTONE. Methodist Chapel, Shrewsbury Road. Dr. M.V. Wilby & Miss W. Morris.	Monday afternoon.	107	1577
CAWTHORNE. Golf Club (Weighing Centre only) Miss E.C. Wroe.	Wednesday a fternoon.	41	501
STOCKSBRIDGE. British Hall. Dr. D. Patterson & Miss W. Morris.	Tuesday afternoon.	196	2417

ANTE-NATAL AND OTHER CLINICS.

Name and Address of Clinic. Na me of Doctor and Nurse in attendance.	Day and Times of sessions.	Tota l Number of attendances
ECCLESFIELD. Gatty Memorial Hall. Dr. M. Rushbrooke & Miss B.S.Ward.	Thursday p.m.	1202
HIGH GREEN. Methodist Sunday School. Dr. J.M. Taggart & Miss E. Gerrard.	Wednesday p.m.	42.
HOYLAND. Miners' Welfare Institute, Dr. M. Allott & Miss M.F. Senior.	Monday p.m.	560.
HOYLAND COMMON. Christ Church, Hoyland Road, Dr. M. Allott & Miss D. Rimmer.	Wednesday p.m.	341.
PENISTONE. Shrewsbury Road Methodist Chapel. Dr. M.V. Wilby & Miss W. Morris.	1st Friday a.m.	38.
STOCKSBRIDGE. British Hall. Dr. D. Patterson & Miss W. Morris.	1st and 3rd Friday p.m.	224.

LYING-IN ACCOMMODATION.

Hospital accommodation for Maternity cases is, of course, the responsibility of the Regional Hospital Board. This Division is served in the main by the Sheffield Hospitals, the Hallamshire Maternity Hospital, the St. Helen Hospital, Barnsley, and the Princess Royal Maternity Home in Huddersfield. The accommodation for Maternity cases is very limited, a circumstance which is fairly general throughout the Country as a whole.

There are two schools of thought with regard to confinements:

(1) that the child should be born in a Hospital where all facilities are available for the Mother and the baby, and

(2) that the most satisfactory arrangement is for the child to be born a t home.

Admittedly it is much easier for the Doctor in the Hospital where everything is to hand. The Mother has a change from her domestic surroundings which, in many cases, is an added advantage. The other school argue that Domiciliary Midwifery is the more important, saying in effect that Midwifery came naturally and traditionally within the sphere of general practice, and that the family Doctor was traditionally the rightful person to act as the family Accoucheur.

I feel in my own mind that what is driving the expectant Mother to Hospital to have her baby is the lack of adequate housing and adequate facilities in which to have the baby in the home and, of course, the lack of domestic help. The average person today has learned a little about health matters, and in the sphere of Midwifery the expectant Mother has learned a lot a t the Clinic, read a lot in pamphlets and advertisements, talked a lot to the past generation of Mothers. She has come to the conclusion that the baby, when it arrives, should arrive in reasonably decent circumstances in the interests of her own health and that of the ba by. She therefore rightly says that "if I cannot have a reasonable standard of conditions in my own home commensurate with what I have been taught, then I must try and have my baby in Hospital."

At the present moment the allocation of beds is made on a strictly priority basis, and roughly speaking they are:

(1) **Primipara.**

(2) Patients whose home conditions are unsatisfactory based on a report of the Health Visitor.

(3) Patients in which an abnorma lity of pregnancy is present, was present, and might have been present in previous pregnancy.

Whilst I cannot sa y that I am entirely satisfied with the accommodation available for cases in Division 22, I am very happy to say that the relationship which exists between me and the Medical Superintendents of the respective Institutions mentioned above is such that I have a lways received mos: sympathetic consideration when any particular case required Hospita lisation. Such a happy relationship between the Local Health Authority and the Regional Hospital Board is a most valuable contribution to the Health Service generally.

CARE OF THE PREMATURE INFANTS.

During 1949 the total number of Premature births in the Division was 61, of which 16 were born and nursed entirely at home. Of these 16, 2 died within 24 hours. Whilst we deprecate even the loss of two Premature babies, it is very gratifying to be able to report that approximately 97% of all the Premature babies in the Division survived at least the first month.

One of the important factors in the reduction of Infantile Mortality generally is the amount of work being done in the study of the care of the Premature Infant. Prematurity used to rank with the infections as the biggest killer in the very youn g. In recent years campaigns have been waged to reduce the mortality in such infants, and to prepare schemes for the care and welfare of the Premature baby. The West Riding County Council have been very much alive to this fact, a nd every encouragement has been given to this important branch of Preventive Medicine.

The Sorrento Maternity Hospital in Birmingham provide a comprehensive course in the care and welfare of Premature Babies. Vacancies in this Hospital for students are few, but the West Riding County Council decided that there should be one Health Visitor a t least in every Division who should undergo this course of training. Latterly the policy was altered to include Midwives as well as Health Visitors, and despite the scarcity of vacancies, we have in Division 22 one Health Visitor already tra ined, a nd one Midwife who hopes to undergo the training early in 1950.

The real function of such trained staff is that they make themselves available to visit a home when a Premature baby is born, and to advise in the ca re and welfare of that baby until the baby is fit to withstand the routine of a normal baby. Of course, there is always the County Paediatrician in the background who is available to go to the assistance of both Midwife and Sorrento trained personnel with his advice. We have also the General Practitioner who may be called to the case first of all, and they advise in the care and welfare of the Premature child. In division 22 we have a staff of Midwives and District Nurse Midwives who are well qualified and highly efficient. I think tha t the care of the Premature baby should be the duty of the Midwife.

An important part of the equipment for the care of the Premature babies a t home is the availability of a Sorrento Cot. This is a specially designed Cot, with all the necessary material in the way of blankets, hot water bottles, Oxygen Cylinder, etc. Each Division has been provided with such a Cot, which is stored at a convenient Centre and can be conveyed when required to the home of the Premature baby. The Cot for Division 22 is stored at the Divisional Offices.

DENTAL TREATMENT.

Dental treatment is provided for expectant and nursing Mothers attending Child Welfare Centres and Ante-Natal Clinics. It is very important that these cases should receive treatment for dental caries, and I think that these persons are receiving the treatment necessary. Before the coming into being of the National Health Service Act, the Medical Officer at the Clinic recommended the necessa ry treatment, but since the 5th July, 1948, every case is entitled to a dental examination, and if the Local Authority's Dental Officer is not available, General Dental Practitioners, in this Division at least, a re most co-operative and give priority treatment to expectant Mothers. It is interesting to report the interest being taken in their dental health by expectant a nd Nursing Mothers and, of course, not only are they interested for themselves, but the interest has spread to the care of their children's teeth, and indeed all other members of the family.

In Division 22 during the year under review we had the exclusive services of one School Dental Officer, and the services of another Dental Officer working partly in this Division and in a neighbouring Division. As you are no doubt a ware, Dental Officers are scarce, and we have been fortunate in being able to have such an amount of Dental Service. It will take some time to overtake the amount of work that is to be done in the Schools as a result of the lack of Dental service during the latter part of the wa r, but I am confident that in Division 22 the very near future will see the Dental Service abreast of the requirements of the children, and that satisfactory service will be maintained.

Statistics of Routine Dental Treatment carried out in Division 22 during 1949.

Number of inspections		1195.
Number offered treatment		1034.
Number Treated		815.
Number of attendances		2377.
Number of extractions	T (temporary dentition)	1666.
	P (permanent dentition)	141.
Number of Fillings	T (temporary dentition)	525.
	P (permanent dentition)	1290.
Number of Other Ops.	T (temporary dentition)	487.
	P (permanent dentition)	341.

Dental Treatment of Expectant and Nursing Mothers during 1949.

83 cases referred.

38 failed to attend.

45 either treated or under treatment.

SUPPLY OF MILK AND OTHER FOODS.

Dried Milk and other foods are sold and distributed at Child Welfare Clinics according to the scheme which has been in operation for some years. Briefly, this scheme provides for the free issue of foods under certain conditions, and generally the sale of foods at slightly reduced rates. Needless to say, it has become a very important item in the Clinic procee dings, and in some Clinics calls for the special attendance of a representative from this Office. In other Clinics public spirited and well meaning ladies assist the Nurse in the distribution of this food.

There have been arguments for and against the distribution of foods at Clinics. It has been stated that the first impression on entering a Clinic was that it was more of a shop than a Centre for Health Teaching. I do not think this is the time to incite controversy about such a matter. The great point is that the Mothers and the babies attending the Clinic are getting the service and that seems, to me at any rate, to be the immediate important factor. So long as the Clinic is not to be recognised as a Food Sales Department, I do not mind, but I do object to a system where the obtaining of foods at a cheaper rate means more to the Mother and baby than the health educative element which we try to offer.

I have just mentioned those well meaning ladies who assist at the Clinics, and I think that it is only fair that I put on record my thanks to those ladies for their contribution in a most important section of the Health Service. These ladies, who work under the direction of the Health Visitor and the Medical Officer, are volunteers giving of their time and effort, and many have given long and faithful service. I think it is safe to say that in many Clinics the work would not be carried out so smoothly without their valuable help.

Some idea of the am ount of work and time involved in the scheme for the distribution of Dried Milk and other foods can be obtained by glancing at the undermentioned table, which gives the yearly sales of the more popular branded supplies. For comparison I have given the comparative sales for 1948.

I must explain the reduction in the sale of Sunrose Dried Milk. This is a product which was made to a formula prepared by an ex County Medical Officer of the West Riding, and made specially for distribution within the County of the West Riding. This product is being discontinued, and this explains the reduction in the quantity of sales.

CLINIC.	Virol		Glucose		Sunrose		Ostermi		Cow & Ga		Trufood.		Olive O	
	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949	1948	1949
CAWTHORNE... ...	152	109	1105	665	416	1	108	65	458	255	228	176	14	3
CHAPELTOWN.. ...	79	104	382	258	687	197	417	360	1263	893	-	65	52	36
ECCLESFIELD ...	143	256	538	877	1363	883	1531	2548	1169	713	142	304	63	46
GRENOSIDE... ...	112	116	498	376	192	168	268	202	350	279	9	-	41	3
HIGH GREEN.. ...	98	119	340	435	475	78	669	883	1028	1348	-	48	91	89
HOYLAND	81	182	2115	1320	1553	443	646	982	1943	3090	200	125	78	52
HOYLAND COMMON...	128	214	1774	1438	551	354	591	583	2594	2127	24	181	75	36
LOXLEY	63	38	417	360	173	54	567	583	-	-	9	-	5	4
OUGHTIBRIDGE ...	77	89	553	568	439	324	174	228	541	435	-	-	29	22
PENISTONE... ...	72	67	487	391	237	43	108	142	385	486	-	-	53	-
STANNINGTON ...	110	72	494	648	343	279	943	1453	278	252	74	48	11	-
STOCKSBRIDGE ...	61	119	785	954	1849	264	300	825	1194	1295	-	-	69	31
TANKERSLEY.. ...	44	23	459	332	-	-	-	-	307	223	-	22	68	32
WORRALL	96	47	263	257	146	22	483	275	-	28	12	-	-	8
TOTALS...	1316	1555	10210	8879	8424	3110	6805	9129	11510	11424	698	969	649	362
PACKINGS.	1-lb. Cartons.		¼-lb. Packets.		1-lb Tins.		1-lb Tins.		1-lb Packets.		1-lb. Tins.		8-oz. Bottles.	

HEALTH VISITING.

There has been a great strain on the Health Visiting Service in Division 22 during 1949. The reason for this has been that we have been working with a reduced staff. The establishment of Health Visitors for Division 22 should be 14, and at the present time we are working the service with 6 full-time Health Visitors, 2 part-time and 4 assistant Health Visitors.

The appointment of well qualified and well chosen Nurses as assistant Health Visitors has been a most valuable factor in the service during the last two years. These Nurses work under the direction of a Health Visitor, and their work, particularly in connection with Schools and in some Clinics, has been most inspiring.

During the year Miss E.M. Homeyer, the Health Visitor who served the Stannington, Loxley, Worrall and Bradfield area, resigned on account of ill health and her post has never been completely filled. The area has been covered by a part-time Health Visitor, Miss G.A. Gosney.

The new Health Service Act has opened vast new fields of work for the Health Visitors. The old conception of Health Visiting is changing, and the Health Visitor, in future will become a most important link in the chain between the Regional Hospital Board and the Local Health Authority, and between the Local Health Authority and the General Practitioner. I think it can be said that she will be the bridge by which continuity of care and after care of the individual can be maintained. This demands that the Health Visitor of the future will possibly require an alteration in the type of training to fit her for this new task. At a higher level this idea has been debated and I think, generally speaking, has been accepted. The Health Visitor of the future will have a broader conception of social work than her predecessor. It must not be inferred from this, of course, that the Health Visitor of the past did not have a very wide knowledge of every-day social problems. On the contrary, her hard slogging duties and her self devotion to her task gave her a practical training which made her the fountain of information and knowledge of the way people in her district lived, and the way people live, and how they should live is the Health Visitor's field of work.

I am glad to report that during 1949 there has been a marked improvement in the integration of the work of the Health Department and the General Practitioner. In the field of Medicine the family Doctor is one of the most hard worked men in the Country today, and the family Doctor is beginning to realise that in the Health Visitor he has a wonderful ally, and that her presence in the vicinity can mean such a lot to the environmental background of his work.

An integration of the duties of the Health Visitors and the Hospital Almoners is beginning to be appreciated. I am certain that the Act envisaged a time when there would be a link between the Hospital Service and Local Health Authority Service, i.e. the Treatment Department and the Care and After-care Department. That link is the Health Visitor. Before the new Act came into force, the Hospital Almoner savoured of investigation into the ways and means for payment of maintenance of the patient in Hospital. Now, happily, this mundane feature of the Almoner's work has disappeared and she now interests herself in the environmental background of the in-patient. How can the Almoner get a true picture of the family background of the in-patients without liaison with the district from which the patients come ? In other words, her work, to be done satisfactorily, must involve a study of the social conditions of the family of the patient. Who can do this better for her and with her than the Health Visitor ? There ought to be a close co-operative working arrangement between the Almoners and the Health Visitors, and I am very happy to report that in Division 22 this arrangement is beginning to become apparent. If I might be forgiven for putting the matter simply, might I just describe an imaginary case. A woman is visited by her own Doctor and transferred to Hospital for emergency Surgical treatment. The time arrives when the patient can be moved to her home. Is it fair

to send the patient home if the conditions of the home are such that the after-care cannot be dealt with satisfactorily ? The Almoner gets the family story from the patient, she contacts the Health Visitor through the Divisional Medical Officer for an up to date report on the home environment, and a report is passed forward to the Surgeon to say that conditions at home are satisfactory for the patient to be returned home, or are not satisfactory for the patient to be returned home. Furthermore, the Health Visitor is made aware that the patient is returning and can integrate her duties with the work of the General Practitioner for the welfare of the patient generally. This is to be one of the most important functions of the Health Visitor, and this service must be used to its fullest extent.

I would like to put on record here my deep appreciation of the valuable work the Health Visitors in Division 22 have done during 1949, when the staff was depleted and the work was long and arduous. Nevertheless it was well done. The following table shows the disposition of the Nurses throughout the Division.

HOYLAND NETHER U.D.

NURSE D. RIMMER	HOYLAND COMMON.
NURSE M.F.SENIOR	HOYLAND, PLATTS COMMON, ELSECAR.
NURSE E. CHETTLEBURGH (Asst.H.V.) ...	-do- -do- -do-

STOCKSBRIDGE U.D.

NURSE W. MORRIS	STOCKSBRIDGE, BOLSTERSTONE.
NURSE D. SILL	DEEPCAR.
NURSE H. DRANSFIELD (Asst.H.V.) ...	STOCKSBRIDGE and PENISTONE.

PENISTONE U.D.

PENISTONE R.D.

These areas are covered by NURSE E.C. WROE (Appointed July,1948).

WORTLEY R.D.

NURSE E. GERRARD) NURSE D.M.SIMPSON) (Asst.H.V.) ...	CHAPELTOWN, HIGH GREEN, WARREN. BURNCROSS, THORPE HESLEY.
NURSE B.S. WARD) NURSE L.M. BEAUMONT) (Asst.H.V.) ...	ECCLESFIELD, PARSON CROSS GRENOSIDE.
NURSE G.A. GOSNEY	STANNINGTON, LOXLEY, WORRALL, BRADFIELD

COUNTY DISTRICT.	HEALTH VISITOR.	ADDRESS.	TELEPHONE NUMBER.
HOYLAND NETHER U.D.	Miss D. Rimmer.	6, Kirk Balk, Hoyland.	Hoyland 3179.
	Miss M.F. Senior.	24, St.Andrews Cresc. Hoyland.	
	Mrs.E. Chettleburgh (Assistant)	46, Cherry Tree St. Elsecar.	
STOCKSBRIDGE U.D.	Miss D. Sill. (Part-time)	15, Smithy Moor Avenue, Stocksbridge.	
	Miss W. Morris.	15, Smithy Moor Avenue, Stocksbridge.	
	Mrs. H. Dransfield. (Assistant)	"Skelton Villa", 29, Pot House Lane, Stocksbridge.	
PENISTONE R.D.	Miss E.C. Wroe.	c/o Booth, 12 Royd Rd. Millhouse, Penistone.	
PENISTONE U.D.	Miss E.C. Wroe.	c/o Booth, 12 Royd Rd. Millhouse, Penistone.	
WORTLEY R.D.	Miss E. Gerrard.	28, Loundside, Chapeltown,	
	Mrs. D.M. Simpson. (Assistant)	Potter Hill Lane, High Green.	
	Miss B.S. Ward.	95, Trap Lane, Sheffield.11.	
	Mrs. L.M. Beaumont. (Assistant)	4, Green Lane, Ecclesfield.	
	Miss G.A. Gosney. (Part time)	"Clovelly", 379, Stannington Rd., Sheffield.6.	

HOME NURSING.

Before the 5th July, 1948, Home Nursing was a service provided in most cases by District Nursing Associations. This service is now a function of the Local Health Authority, as prescribed in the National Health Service Act. On the "Appointed Day", therefore, the County Council as the Local Health Authority became responsible for the Home Nursing Service. This was not an easy task, in that some areas had been exceptionally well nursed, and some areas had had no nursing at all. The task before the Local Health Authority was to bring the best possible service to all. Division 22 was most fortunately situated in this respect, in that every district in the Division was covered by an existing efficient District Nursing Association. The Nurses employed by this District Nursing Association in every case transferred services to the County Council and remained in the area as the District Nurse and/or Midwife.

District Nurses in the past used to undertake Home Nursing and Midwifery work, but the policy of the Local Health Authority made it clear that it would be better to separate the services, and that a Nurse should either do Midwifery or Home Nursing, not both duties combined. This could possibly be arranged in areas which were more or less Urbanised, but in the scattered Rural areas, the difficulties in separating the services were so involved that separation of the services was deferred in those areas for the time being. You will see from the undermentioned table that in two parts of Division 22 we still have a District Nurse Midwife Service.

In Division 22 the Home Nursing Service is carried out by 7 Home Nurses and 5 District Nurse Midwives. Towards the end of the year complete separation of the two Services in one district was arranged, which would reduce the District Nurse Midwives early in 1950 to 3, and at the same time increase the number of Home Nurses to 8. During the year nearly 22,000 visits were paid by Home Nurses, more than double the number of visits made in 1948.

I wonder if it is generally understood what the functions of the Home Nurse really are ? The Home Nurse is a full y trained and efficient Nurse, who will render in the home that service which a patient would get from a trained Nurse in Hospital. The Home Nurse can relieve the General Practioner of much of his work by doing those duties in the home which her counterpart would be asked to do by the House Surgeon or House Physician in Hospital. In the past it was generally accepted as the Home Nurse's job to go around doing menial pseudo-nursing tasks in cases of chronic illness, tasks that could have been easily done by a member of the family or some neighbour or relative. It is uneconomical to use the time and energies of highly trained and skilled Nurses in any other manner than the performance of skilled nursing duties.

It is agreed that in all cases of illness, that besides the Medical treatment, skilled Nursing is of vital importance. Why not use the skilled Nursing ability available in cases of illness ? Happily, in parts of Division 22 the General Practitioner is beginning to realise the value of a good Home Nurse, and the time will surely come when she will take her place as a most essential functionary in the Health Service.

At the present moment I think that the distribution of work amongst these Home Nurses is too irregular. Some Home Nurses have much to do, whilst others have less. Determined efforts are being made to even out the work and to spread it over wider areas. We must get rid of the impression which has understandably existed since the days of the District Nursing Association, that a Home Nurse or Midwife has a particular area in which she works, and she is not available in any other area. We must get rid of this erroneous idea. Nurses employed by the Local Health Authority are available for service in any part of a Division if the need for that service exists.

Another point which it is hoped will be rectified in the near future is the appointment in this Division of a Relief Home Nurse who would relieve the various Home Nurses for their "days off" and in times when duties are arduous. We have a Relief Midwife who does just this for Midwives, and the same is necessary for the Home Nurses. The Home Nurses and District Nurse Midwives on the staff of Division 22 all possess a high degree of skill in their work, and are doing a magnificent job. All the Nurses except one are mobile, and it is hoped that it will not be long before this Nurse is provided with transport facilities.

I would like to see the Nursing personnel wearing a neat and attractive uniform. Maybe when economic pressure is less severe, this uniform question for Nursing staffs will be reconsidered.

COUNTY DISTRICT.	HOME NURSE.	ADDRESS.	TELEPHONE NUMBER.
HOYLAND NETHER U.D.	Mrs. M. Bramley.	16, Mell Avenue, Hoyland.	Hoyland 2181.
PENISTONE U.D.	Miss K.J. Mark.	34, Victoria Street, Penistone.	Penistone 167.
	Miss M.A. Smith.	34, Victoria Street, Penistone.	Penistone 167.
STOCKSBRIDGE U.D.	Miss D. Webb.	61, Melbourne Road, Garden Village, Stocksbridge.	Stocks-bridge 3165.
PENISTONE R.D.	Miss K.J. Mark.	34, Victoria Street, Penistone.	Penistone 167
	Miss M.A.Smith.	34, Victoria Street, Penistone.	Penistone 167.
	Mrs. C. Bennett.	12, Netherfield, Crane Moor, Thurgoland.	Stocks-bridge 2159.
WORTLEY R.D.	Mrs. A. Woodhead.	1a, King Street Charlton Brook, Chapeltown.	Ecclesfield 38582.
	Mrs. I. Rose.	133, Wheata Road, Parson Cross.	
	Miss H.G. Peacock.	Jeffcock Memorial Nurses Home, Ecclesfield.	Ecclesfield 38438.
	Mrs. N. McNamara.	Dale View, Rodney Hill, Loxley.	Sheffield 43643.
	Miss A.I. Middleton.	17, South Road, High Green.	High Green 25.
	Mrs. A. White.	7, Highfield Rise, Stannington.	

MIDWIFERY SERVICE.

The Domiciliary Midwifery Service in Division 22 is undertaken practically exclusively by whole-time Midwives employed by the Local Health Authority. In some instances District Nurse Midwives doing the combined duties of Midwifery and Home Nursing, are employed e.g. Loxley and Oughtibridge. In the Silkstone area the Nurse has opted for the Midwifery Service, and she does Midwifery exclusively. In the Loxley area the same thing has happened, where early in the new year there will be a division of the Nurses' duties, when one will confine herself exclusively to Midwifery, the other to Home Nursing. The arrangements in Division 22 for Domiciliary Midwifery are very satisfactory. In one part of the district, e.g. Parson Cross Estate, in the Wortley Rural District, virtually a new Town has arisen and, of course, extra staff are required to deal with that situation. We have now two Midwives living on the Estate and one living in the Nurses Home on the edge of the Estate. I am not entirely satisfied that there are sufficient Midwives to cover that area, but the situation is continually being reviewed.

During 1949, according to the Notification of Births Register, 716 Domiciliary Live Births occurred and 727 Institutional Births. There were 15 Still Births in the Domiciliary Service and 7 in Institutions. The total figure, 1,465, approximates fairly closely to that for 1948. In the Division there are 10 Midwives, including one Relief Midwife, and 5 Home Nurses undertaking Midwifery. Over and above this we have 4 Midwives practising Private Domiciliary Midwifery. Those numbers, of course, do not include the Midwives employed in the Hallamshire Maternity Home, which Institution is under the administration of the Regional Hospital Board.

During the year the Nurses sent Medical Aid Notices to General Practitioners for help on 255 occasions, 42 for Ante-Natal cases, 166 Labour cases, and 17 during the lying-in period, and on 30 occasions help was requested for the infant. In Division 22 there were no maternal deaths during the year. This is a very happy state of affairs.

I mentioned in my report for 1948 that one of the important factors in organising a Midwifery Service is to ensure that the Midwife, when summoned, can get to the case speedily, with all her equipment, and in a reasonable physical condition to perform maybe a long, difficult and highly skilled task. To obtain this state, it is essential that the Midwives should be mobile, and in this Division all Midwives are mobile except one, and at the moment she is not suffering any inconvenience, as her practice is within easy reach of her own home. However, we trust that she will be mobile in the near future. So much is this need for transport for Midwives recognised at Government level that they are given very high priority in the purchase of new Cars.

With the new arrangements in the National Health Service Act for Domiciliary Midwifery on the part of General Practitioners, much more of the Midwife's work is in the capacity of a Maternity N urse. It means that in very many more cases the General Practitioner is actually responsible for the confinement in which case the Midwife acts in the capacity of a Maternity Nurse. This is a state of affairs which is very helpful when the expectant Mother knows that she has a Doctor and a highly trained Midwife to be in attendance when her baby arrives.

ANALGESIA IN CHILD BIRTH.

Closely bound up, of course, with Midwifery we might comment on the question of Analgesia in Midwifery. Analgesics were administered by Domiciliary Midwives in 33 instances during 1949 in this Division, and this out of a total of 731 Domiciliary births. In the Division there are 12 Gas and Air Machines, and I understand that supplies of these machines are coming through reasonably quickly, and that all Midwives trained to use those machines will be equipped with one in the near future. At the end of 1949 there were 14 Midwives or District Nurse Midwives trained in the use of the machine. Looking at the above figures it is difficult to reconcile the popular clamour for the relief of pain in child-birth when one finds that only 33 cases had relief during the year. Of course, many of the cases might have required medical help, when an anaesthetic would have been administered, but even then there could not have been a very great total of cases relieved.

There has been a lot of talk about the question of Analgesia in child-birth. The relief of pain in labour has always been a problem, and we have in the Gas and Air Outfit, when used by a skilled operator, a simple and efficient means of giving this relief. I think that expectant Mothers are just not too sure about this machine. I think that if they were educated in its use by having the machine demonstrated to them and they being allowed to handle it beforehand, when the time arrives for their confinement they will have absolute confidence in using it, and in the Midwife's ability to operate it.

I have heard it said that this Analgesia is no use at all. On the other hand I have heard Midwives say that it is wonderful. In theory it is the answer to the relief of pain in child-birth.

COUNTY DISTRICT.	MIDWIFE.	ADDRESS.	TELEPHONE NUMBER.
HOYLAND NETHER U.D.	Mrs. H.A.Knowles.	88, Cherry Tree St., Elsecar.	Hoyland 2249.
	Miss N. Walker.	8, Skiers Hall, Elsecar.	Hoyland 3104.
PENISTONE U.D.	Miss K.J. Mark.	34, Victoria Street Penistone.	Penistone 167.
	Miss M.A. Smith.	34, Victoria Street Penistone.	Penistone 167.
STOCKSBRIDGE U.D.	Miss A. Burrows.	"Hazeldene", Coronation Road, Stocksbridge.	Stocksbridge 2189.
	Miss R. Crossley.	7, Ashfield, Deepcar.	Stocksbridge 3135.
PENISTONE R.D.	Miss J.L. Bain.	"Plevna", Silkstone Common.	Silkstone 356.
	Miss K.J. Mark.	34, Victoria Street, Penistone.	Penistone 167.
	Miss M.A.Smith.	34, Victoria Street, Penistone.	Penistone 167.
WORTLEY R.D.	Miss S. Billing.	Jeffcock Memorial Nurses Home, Ecclesfield.	Ecclesfield 38438.
	Miss F.M. Sewell.	93, Mansell Crescent, Parson Cross.	Sheffield 44820.
	Miss K. Jowitt.	8, Worsboro' View, Tankersley.	Hoyland 3154.
	Mrs. N. McNamara.	Dale View, Rodney Hill, Loxley.	Sheffield 43643.
	Miss R.M. Smith.	"The Haven", Bedford Rd. Oughtibridge.	Oughtibridge 40892.
	Mrs. M.E.Quirk.	42, Knutton Road, Parson Cross.	Sheffield 44347.
	Mrs. F. O'Sullivan.	16, Worrall Road, High Green.	High Green 49.

VACCINATION AND IMMUNISATION.

During the year, the number of children immunised was 1,357, and 1,431 children received booster doses. Details are given below:-

County District.	Number of Children Immunised in 1949. Under 5 years.	5 - 14 years.	Total.	Number given Secondary Doses.
Hoyland Nether Urban.	213	164	377	295
Penistone Urban.	60	-	60	105
Stocksbridge Urban.	105	39	144	171
Penistone Rural.	62	13	75	176
Wortley Rural.	584	117	701	684
TOTALS...	1024	333	1357	1431

189 persons were vaccinated during the year, and 21 re-vaccinated. Details are given below:-

County District.	Number Vaccinated	Number Re-Vaccinated.	Total.
Hoyland Nether Urban.	39	9	48
Penistone Urban.	7	2	9
Stocksbridge Urban.	33	1	34
Penistone Rural.	25	2	27
Wortley Rural.	85	7	92
TOTALS...	189	21	210

PREVENTION OF ILLNESS - CARE AND AFTER CARE.

TUBERCULOSIS.

Cases of Tuberculosis notifed within the Division are investigated, with a view to ensuring that the patient obtains all the facilities for treatment, and examination of contacts, at the earliest possible moment. In the Division there are two Tuberculosis Nurses, who now work under the direction of the Divisional Medical Officer and are considered, more or less, in the same category as the Health Visitor. Their work is to follow up every notified case, and keep the Divisional Medical Officer informed about the environmental background of the case. It is from the reports of these Nurses that the Divisional Medical Officer, in his capacity as Medical Officer of Health to the District Council, can advise that District Council as to the necessity for re-housing.

Since the National Health Service Act came into operation, the Tuberculosis service has been made more complicated, and I venture to suggest, more difficult. Pre-National Health Service Act days the Tuberculosis service was exclusively a service of the Medical Officer of Health. The Medical Officer of Health received a notification, the Medical Officer of Health was responsible for Clinical observation and treatment, and the Local Authority was responsible for the provision of Sanatoria and other Institutional lines of treatment. Now, the Medical Officer of Health receives a notification and that, and the epidemiology of the case and the environmental background of the case are the limits of his service. The Clinics, Sanatoria and other Institutions are now the responsibility of the Regional Hospital Board. It is only natural that Medical Officers of Health of large Authorities resented very much the loss of this part of the Tuberculosis Service. But the Medical Officer of Health is not bereft of a wide field of interest in which very useful work can be done. I refer to the Field of Epidemiology. To do this work properly it is necessary for the Medical Officer of Health to get all the information he can from all sources. Information is the chief essential of his armamentarium and we hope the Regional Hospital Boards give us lots of information about all types of illnesses besides Tuberculosis. Your Medical Officer of Health is involved in the fight against this dreadful disease, and you, as a Council have a part to play. Is it not true that bad housing, overcrowding, dirt, as well as poverty and lack of food, are factors predisposing to Pulmonary Tuberculosis ?

I wish to put on record here my grateful thanks to each District Council within the Division for their willing co-operation in helping to overcome the problem of re-housing the Tubercular patient. I know that it is your responsibility to re-house these patients on the advice of the Medical Officer of Health, but in many cases it is difficult to give that priority. You have done so most willingly, and it means a great lot in the Health Service.

The Domiciliary care of Tuberculosis patients is always an important item in the Health Service scheme. These people need continual supervision, and this is done by the Tuberculosis Nurse, the Tuberculosis Medical Officer (now known as the Chest Physician) and, of course, the patient's own Doctor and, if need be, the District Nurse. It may be that one member of the family has to sleep alone in a separate room, in a separate bed. When information is received that it might be an economical strain on the family resources to provide such bed and bedding, these requirements are provided by the Local Authority. The same applies to shelters, which can be established in the garden or any other open space near the home, supplies of ordinary clothing for the patient to wear, and extra nourishment . when it is considered necessary. During 1949, 18 Tubercular patients received extra nourishment in the form of 2 pints of Milk daily over an average period of time of 9 months.

OTHER TYPES OF ILLNESS.

It is the duty of the Local Health Authority, under Section 28 of the National Health Service Act, to make arrangements for "the prevention of illness and the care of persons suffering from illness or mental defectiveness, or the after-care of such persons." This Section makes it an obligation on the part of the Local Health Authority to provide schemes for the after-care of people suffering from all types of illness. For example, patients discharged from Hospital may need care and attention, varying in degree from the provision of appliances to the relief of all the pressure of household duties. This is a new duty, but one that is of vital importance for the welfare of the patient. In the past, as a general rule, patients have returned from Hospital, or recovered from an illness in their own home, and have re-entered into the whirl of the everyday domestic life without any after-care to guard against possible potential ravages of their recent illness. The new Act makes it the responsibility of the Local Health Authority to see that everything is done to make recovery complete, and resolve the physical and psychological difficulties. Now what does this care amount to ? In the main, in Division 22 it has involved the provision of Home Helps, the loan of Bed Rests, Bed Pans, Rubber Sheets, Hot Water Bottles, and in certain cases the provision of complete Bed Units with Dunlopillo Mattresses for paralysed patients. Psychological difficulties have been got over by the occasional visit of a Health Visitor, who, with a sympathetic approach to the problem, has been able to absorb some of the worries and difficulties of the patient, and generally offer a solution. In nearly all cases the General Practitioner, of course, is involved and the Health Visitor, the Home Nurse, or even the Midwife is available to give her service if required.

I would like it understood that the after-care assistance available from the Local Health Authority is not limited to the material things. Advice on any health problem which bears on the patient's future welfare is always available. Generally speaking, the small items which used to be in the keeping of the District Nurse are still obtainable through the District Home Nurse, whilst the bigger items, such as Wheel Chairs and Dunlopillo Mattresses and beds, are obtainable by application to the Divisional Health Office.

MENTAL HEALTH SERVICE.

The Mental Health Service has functioned successfully during the past year and all notified mental defectives are now supervised by a Mental Health Social Worker, who also undertakes After Care of Lunacy cases when requested by patients, which under the National Health Act is now the responsibility of the Local Authority.

There have been 3 notifications under Section 57 of the Education Act, 1944, 6 notifications under the Mental Deficiency Acts, 3 admissions to Mental Deficiency Institutions, 1 de-certification and 3 deaths. The number of mental defectives under supervision as on 31.12.49 is :-

Statutory Supervision.

Over 16 years of age	...	...	65.
Under 16 years of age	...	...	22.

Under Guardianship and in receipt of financial aid.

8.

Under Observation.

13.

On Licence from Institutions.

3.

32 Mental Defectives are in regular gainful employment and 43 are engaged in the home. 42 defectives, including children excluded from School, would benefit by Occupation Centre training and enquiries are still being made in the Division to obtain suitable premises for the establishment of such a Centre, which would serve all mentally defective children excluded from School, and older defectives who would benefit from training in handicrafts, routine methods, etc.

4 patients are awaiting admission to Institutions as their parents are no longer able to give care and attention necessary for their well being. Their names have been included on the list submitted to the Regional Hospital Board and vacancies are now awaited.

DOMESTIC HELP SERVICE.

During the year the Home Help Service continued to play its own vital part in the General Health Service. Towards the end of the year the demand for Home Helps steadily increased, until the position arose when the demand exceeded the supply. When such a condition of affairs arises, it means either the denying of a Home Help to the home, or cutting down the number of hours which the Home Help might spend in that home. According to Section 29 of the National Health Service Act, it is an obligation on the part of the Local Health Authority to make arrangements for the provision of domestic help for households where such help is required. The scheme prepared by the West Riding County Council as the Local Health Authority, and originally submitted to the Minister for his approval, made provision for the supply of 310 Home Helps for the administrative County. Each Division was given a quota of Home Help hours based on a population figure and on the potential requirements of the Division. Division 22 was granted the equivalent of 14 full-time Home Helps. A Home Help's full time week is equivalent to 44 hours, which means that this Division was given a quota of 616 hours per week. During the year there was a tremendous strain on the Service to keep within reasonable bounds of this quota, and I am afraid that to deal with the situation, the quota was exceeded on a number of occasions.

The number of Home Helps employed at the 31st December was 54. Some of these Home Helps were doing part time work, and some doing a full 44 hours per week. During the year there was a total of 34,045, Home Help hours worked within the Division, and 159 cases were attended. These cases consisted of:-

Ordinary illness ...	56.
Lying-In	95.
Expectant Mothers...	3.
Aged Persons ...	5.

This indicates a most valuable service rendered during 1949 which, in view of its particular usefulness in the service generally, must be increased as time goes on.

Certain parts of the Division are still under-staffed, and more Home Helps are required in these areas. I refer to Stocksbridge and Penistone. I know the difficulties, but I am still hoping for more volunteers for this work, which I consider about the most important work a woman can do if she has the time available to do it.

During 1949 a scheme was prepared for the issue of Uniforms for Home Helps. After a probationary period each Home Help is provided with three Green Working Overalls, one White Apron and one Rubber Apron. In theory these articles are on loan, and when the Home Help resigns they are returnable to the Local Authority.

There has been a suggestion that the Home Help Service would be even better if Home Helps were on the same footing as the Domestic Helps in the School Meals Service. The latter are paid a retaining fee when work is not available, and during holiday periods. There are differences, I admit, and it is a big question, but if this most vitally important service is going to be carried out satisfactorily, we must recruit the proper type of women, we must encourage these women to realise that they are performing a vital service, and they must be available at a moment's notice to give that service.

Section 29 of the National Health Service Act, Sub-section 2, says that the Local Health Authority may, with the approval of the Minister, recover charges for this service. During the year under review, approximately £3,500 (three thousand, five hundred pounds) was paid out in wages in Division 22, and the Local Health Authority recovered, through the Divisional Cashier, £216. 2s 8d. (two hundred and sixteen pounds, two shillings and eightpence).

SCHOOL HEALTH SERVICE.

During the year, a total of 2,973 children were examined at routine medical inspections. Of this number, 1,464, were entrants, 917 were in the second and 592 were in the third age group. 130 special inspections and 38 re-inspections were carried out.

One of the great problems confronting the School Health Service today is the totally inadequate provision made for the education of the educationally sub-normal child. During the past twelve months it has not been possible to get even one case admitted from this Division and during the year a further 17 cases were added to the already long waiting list. In the meantime, these children must perforce attend at the ordinary School where their chances of getting really satisfactory education are remote. Many of the educationally sub-normal children examined are not inherently dull but have, owing to illness in early School years, got very far behind educationally. In the education system as it at present exists, these children are placed in the class corresponding to their age group. They make a vain attempt to follow the instruction that is given, but eventually get hopelessly lost and become mere passengers for the remainder of their School career. Special provision for education of these children in special classes in the ordinary School would, in my opinion, alleviate the problem considerably, but apparently this system is not workable under present conditions.

One cannot blame the Teacher of an already over full class for not paying special attention to an educationally sub-normal child, when he or she has a large number of children who are able to take full advantage of the instruction.

It is understood that the West Riding County Council are making arrangements to open three Special Schools for educationally sub-normal children in the coming year, and it is hoped that this step will greatly alleviate the present circumstances.

SCHOOL OPHTHALMIC SERVICE.

During the year a total of 250 Schoolchildren had a Specialist Eye examination, as a result of defects discovered at routine inspection. Of this number 220 were found to be in need of Spectacles, and the prescriptions were issued. I am glad to report that the waiting period between examination and actual issue of Spectacles is now much less than previously, and the time of waiting in these cases averaged between three and four months.

In this Division we are fortunate in having the services of a wholetime Ophthalmologist, whose services are shared by four other Divisions. We are thus able to hold Eye Clinics at five-weekly intervals, and cases requiring more urgent attention are seen by appointment.

NUTRITION.

The standard of nutrition of Schoolchildren today is very satisfactory. According to information given to me the nutritional standard of Schoolchildren during the past 25 years has improved - Dinners, Milk and Cod Liver Oil, without question have brought about this improvement. In the years of the early 20's a wave of undernourished children entered School. This malnutrition was attributed mainly to the shortage and poor quality of food in the closing years of the first World War, with a resulting adverse effect on the expectant Mothers and later their children. This wave of malnutrition was kept under close observation during the School life of these children, and a general sluggishness and retardation, both physically and mentally, was noted. No signs of a repetition of this catastrophe following World War II have been observed, nor is it in any way anticipated. No doubt we are reaping the benefits of the extra attention given to expectant Mothers, and to the maintenance of the essential milk supply to infants.

CLOTHING AND FOOTWEAR.

In spite of the high cost of clothing today, Schoolchildren in general are well clothed, both in quality and quantity. Twenty-five years ago it was a common sight to find children with a layer of brown or greased paper, or cotton wool on their chests and under garments sewn up for the Winter.

The footwear of Schoolchildren is generally of a high standard, and surprisingly few defects are discovered on routine medical examination . We are fortunate in this Division in being able to call on Specialist Orthopaedic advice, which is promptly and efficiently given, in many cases remedial exercises being the only line of treatment necessary.

REMEDIAL EXERCISES.

An interesting experiment was tried out in this Division and in Division 28 in 1948, when the Education Department and the Health Department united forces in an endeavour to deal with comparatively large numbers of minor Orthopaedic defects which were being discovered at routine School Medical Inspections. In short, the position was that mild conditions of flat foot, postural defect, etc. were being referred to the Orthopaedic Surgeon for advice and suggested treatment. The Orthopaedic Surgeon was finding it increasingly difficult to overcome the large number waiting to be seen by him, and it was felt in many of those cases that ordinary exercises as taught by the Remedial Gymnast employed by the Education Department would probably cure the defect in question.

The scheme in brief was that the Remedial Gymnast would call for volunteers amongst the ordinary Teachers in the Schools within the area. These Teachers were to attend a course given by the Remedial Gymnast on the elementary anatomy of the feet, and the type of exercises suitable for the minor foot defects. It was amazing the number of Teachers in the ordinary Day School who attended this Course, and who became thoroughly interested in this work. The next stage was that all children reported at School Medical Inspections to be suffering from a minor foot defect should be referred to the Teacher in that School who had attended the Course, and that he or she undertook to instruct the child in the necessary exercises. Naturally, there was still the continuing supervision of the Remedial Gymnast and the School Medical Inspector, under the control of the Orthopaedic Surgeon.

This experiment has been very successful, and in Schools it is a common feature to have exercises for minor conditions of flat foot included in the normal physical exercises of the Schoolchildren.

SCHOOL PREMISES.

Cloakrooms. In one or two Schools, kitchen facilities for School dinners have been accommodated in School Cloakrooms. This makeshift method is deprecated. Cloakroom accommodation in many of the old School buildings has never been satisfactory, and now that part of the Cloakroom space is being used as a kitchen, the scholars' clothing is crowded together on a few broken hooks and pegs, and often at home time the coats are more damp than on arrival due to the steam and wet floors. This state of affairs is also most unsatisfactory from a hygienic point of view, as School meals are distributed here.

It is unfortunate that the Sanitary arrangements in many of the older Schools in the Rural Districts are still sub-standard. Children attending these Schools have got to put up with a standard of hygiene and sanitation which, in many cases, is much below that to which they are accustomed in their own homes. This has, of course, always been a great problem in Country areas, especially as many of the old Schools still in use are far below the minimum standard of hygiene and sanitation. One has only got to visit one of our modern Schools which has been recently built, to appreciate the enormous advances which have been made in promoting the comfort and well-being of the Schoolchild.

A visit to the new School on the Parson Cross Estate is a wonderful tonic to Practitioners of Hygiene and Sanitary Science. I pay tribute to the Education Authority for the provision of such a Centre of Education.

I feel I ought, at this point, to make a plea that in these most up-to-date Schools the Medical Inspection Room may be retained as such. It must not be assumed that the Medical Inspection Room is for use only at the periodic School Medical Inspection. It should compare with any other room provided for a special function, e.g. Science, Cookery, Handicraft. The Medical Inspection Room should be recognised as the Centre of Health Education in the School, where all teaching relative to health should take place, e.g. Elementary Biology, Hygiene, First Aid, etc. I want to make this plea, for it so often happens that if accommodation has to be found in School for any purpose at all, the Medical Inspection Room is the first to be commandeered. That room should be so much a vital part of the School building that it would be impossible to utilise it for anything other than for School Health Service purposes.

GENERAL.

I would like to emphasise once again a point I mentioned in my report in 1948, viz. that it is in the best interests of the child that the parent or guardian of the child should attend at the School at Medical Inspection time. To run the rule over a child to see whether the child is healthy or not is only one part of a School Medical Inspection. It is also very important that there should be a consultation amongst the four important elements in the child's School health life, the Doctor, the Health Visitor, the Parent (or Guardian) and the Teacher - the child's physical condition, plus the home environmental background, plus the child's little idiosyncrasies within it's family, plus the child's progress in learning. These four informations create a true picture of the child's real health.

All the Schools in Division 22 were visited during the year under review, and below there is a short statistical statement concerning some of their findings. Unfortunately we cannot give details for each separate School, since all statistics are merged together as a complete County unit.

Estimated number of School Children at December, 1949 ... 13,250

Number of Medical Inspections carried out within Division 22 during 1949:-

Entrants	1,464.
Second Age Group - last year in Primary School ...	917.
Third Age Group - last year of School life ...	592.
	2,973.

SPECIAL INSPECTIONS.

Special Inspections	130.
Re-Inspections	38.
	168

NUMBER REQUIRING TREATMENT.

Entrants	273.
Second Age Group	164.
Third Age Group	122.
	559.

GENERAL CONDITION OF PUPILS.

	A Good.	B Fair.	C Poor.
Entrants	615	793	56
Second Age Group	500	397	20
Third Age Group	410	179	3

INFESTATION WITH VERMIN.

Total number of examinations in the Schools by School Nurses/Health Visitors	32,083.
Total number of individual pupils found to be infested ...	1,962.

No Cleansing Notices (Sect.54 (2) Education Act, 1944) or Cleansing Orders (Sect. 54 (3) Education Act, 1944) were issued during the year.

The biggest group of conditions requiring attention were those associated with diseases of the Ear, Nose and Throat, and cases of defective vision. There were quite a number of skin conditions, but rather less than a year ago. One of the bottle-necks which we have not yet cleared away is the delay in the provision of facilities for children having Tonsils and Adenoids removed. This is a very big question, and in short it can be summed up as a result of the change over of the treatment part of the Health Service to the Regional Hospital Boards, coupled with the complete cessation of such operations during the prevalence of cases of Acute Anterior Poliomyelitis. It is going to be a hard task to catch up on the number of cases requiring attention, and this matter is receiving the very close attention of the authorities at County level.

PROVISION OF MEALS IN SCHOOLS.

There are two Educational Divisions within Division 22 of the Preventive Medical Services Scheme. These are the Wharncliffe Division (No.19) and Penistone Division (No.31). The School Meals Service in those two Divisions is now complete, and all children can be provided with a meal if it is so desired. Meals are prepared in central Canteens in certain instances, and in other instances in specially constructed Kitchens within the curtilage of the School premises. In the former, meals are conveyed in specially designed heat retaining Containers to the various Schools within the area of the central Canteen. I have made a point of looking at these Containers from time to time, and have been impressed by their state of cleanliness and repair. Needless to say they may play a most vital part as a cause of an outbreak of Food Poisoning, and it is very encouraging to know that those who handle these Containers are deeply appreciative enough of this fact that the necessary care and attention is paid to the question of cleansing.

Also, on various visits to Schools I have been impressed by the quality of the food supplied. It is varied in character and generally forms a complete meal. We preach in Health Education that it is an essential part of good social behaviour to wash the hands thoroughly before partaking of a meal. In School, where the meal can play an important part of the training of social habits, it is undoubtedly of first class importance that provision should be made for the children washing their hands before a meal. This imposes upon those in charge the duty to make sure that the children in fact do this job thoroughly. The School Meals Service is a comparatively new experience in Schools, and the washing facilities available in the older Schools were not designed to meet this new system. Nevertheless it is very encouraging to know that Head Teachers in Schools are overcoming this difficulty, and this elementary hygienic principle is being carried out.

In the two Divisions I am informed that practically 80% of School Children remain for meals, and during 1949 a grand total of 1,415,523 meals were served in Schools.